THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services
DIVISION OF HEALTH CARE SERVICES
Quality Assurance Unit
4501Business Park Blvd., Suite 24, Bldg L
Anchorage, Alaska 99503-7167
Main: 907.334.2400
Fax: 907.561.1684

June 20, 2014

Member Name
c/o Legal Guardian *(if applicable)*
Address1 Address2
City, State Zip

RE: Alaska Medicaid Coordinated Care Initiative: Reference#

Dear Member Name,

The Division of Health Care Services (DHCS) conducts periodic reviews of how Medicaid recipients are using Medicaid services. The Division reviewed your services and found that you used a higher number of Medicaid Emergency Room visits when compared to other Alaska Medicaid members. Your Medicaid claims history showed you used the emergency room five times or more during the 18 month review period January 1, 2012 through September 17, 2013.

Normally, this over-use requires further review to determine if your use should be restricted to one medical provider and one pharmacy as allowed under Medicaid regulation 7 AAC 105.600. **However, instead, we are offering you the opportunity to voluntarily participate in a new program called the Alaska Medicaid Coordinated Care Initiative (AMCCI). Please see the enclosed brochure for more information.**

By volunteering to participate in the AMCCI program, you will receive personalized one-on-one attention and services from a case manager who will assist you to make appointments, access services, address problems, and obtain referrals to specialists, as needed. You may choose to keep your current providers. The AMCCI is there to help members coordinate their care in the health care system and make the most appropriate use of the benefits of the Alaska Medicaid program.

Your participation in the AMCCI is NOT required. If you choose NOT to participate in the AMCCI, the number and type of services you have used will continue to be reviewed periodically and your use of Alaska Medicaid services *may* still be restricted if certain conditions are met under Medicaid regulation 7 AAC 105.600.

Please check ONE of the boxes and sign below. If you are the legal guardian, you may sign for the member.

☐ I DO want to participate in the AMCCI ☐ I DO NOT want to participate in the AMCCI

Signature: _____ Date: _____
Please check this box if you are signing as the legal guardian of this member ☐

Please return this letter in the pre-paid return envelope no later than July 11, 2014, even if you do not wish to participate in the AMCCI. If you decide to participate in the program, you will receive a welcome packet with more information and additional forms to return. If you have questions before signing up for the program, please call me or one of our Quality Assurance Team Representatives: Diana McGee (907) 754 – 3434 or Stephanie Purcell-Reynolds (907) 334 – 2460.

Sincerely,

Debra Taylor

Debra Taylor JD, BSN, RN
DHCS Quality Assurance Manager
(907) 375 - 6468